TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME LLC

Respondent Name
Safety National Casualty Corp

MFDR Tracking Number
M4-15-2660-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We first submitted our claim to Gallagher Bassett on 11/18/2014 and received a denial on 01/02/2015. We then sent an appeal on 01/27/2015 with all the supporting documentation proving they are the payor. We then received a denial on 02/16/2015 again stating they are not the payor."

Amount in Dispute: $1,060.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment was issued on 2/21/15 in the amount of $1,038.57 on check number 116523408 and the status shows as ISSUED."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 10, 2014	L2810, A9901, L1833	$1,060.39	$765.84

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Request for reconsideration

Issues

1. Is the carrier's position statement reporting payment of disputed services supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier states, "Payment was issued on 2/21/15 in the amount of $1,038.57 on check number 116523408…" Although the carrier contends that it paid for the services in dispute, no documentation was found to support that the carrier issued the payment to the requestor. Therefore, the Division will review the services in dispute per applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §134.203(d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

   (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

   (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or

   (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

   The services in dispute will be calculated as follows:

   - Procedure code L2810 -RT, date of service November 10, 2014, is a DMEPOS item subject to 125% of the DMEPOS fee schedule. The amount shown on the applicable fee schedule for the date of service in dispute finds the allowable to be $76.66 x 125% = $95.83
   - Procedure code A9901, date of service November 10, 2014, is classified by Medicare as statutory exclusion. 28 Texas Administrative Code §134.203(b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits;" Therefore, the Division finds no additional reimbursement is recommended.
   - Procedure code L1833 –NU, date of service November 10, 2014, is a DMEPOS item subject to 125% of the DMEPOS fee schedule. The amount shown on the applicable fee schedule for the date of service in dispute finds the allowable to be $670.01.
3. The total allowable for the services in dispute is $765.84. The carrier did not provide supporting evidence of a payment but the health care did provide an EOB showing no payment therefore the amount recommended is $765.84.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $765.84.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $765.84 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		July 31, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.